

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13218

CERTIFICATE OF DEATH

13215

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Parker Bailey</u>		4. DATE OF DEATH Month Day Year <u>Dec. 14, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Ticket Agent B&O R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dillsburgs, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Noah Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Weist.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Frances Bailey, Jessup, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last. (b) <u>10 yrs.</u> (c) <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>15 min</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1950</u> to <u>Dec. 14, 1957</u> that I last saw the deceased alive on <u>12/14/57</u> and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D. <u>Savage</u> DATE SIGNED <u>MD</u> PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Dec. 16, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Donakson</u>		24a. REC'D BY REGISTRAR <u>DATE</u> <u>DEC 20 '57</u> 24b. REGISTRAR'S SIGNATURE <u>E. Bird Williams</u>	

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

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13219

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13216/9/1

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 3 weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor 06 x 1.2		d. STREET ADDRESS Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elsie Middle Baker Last Bollinger		4. DATE OF DEATH Month December Day 4 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 20, 1877 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Windsor, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harry Baker		14. MOTHER'S MAIDEN NAME Anna Hahn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213 38 6679 B	
17. INFORMANT Mrs. Harry Hughes, New Windsor,		Address Rural, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, hypostatic, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular accident—rt hemiplegia DUE TO (c) Arterio sclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 30 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute brain syndrome with arteriosclerosis & cerebral hemorrhage.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 12 , 19 57 , to Dec. 4 , 19 57 , that I last saw the deceased alive on Dec. 4 , 19 57 , and that death occurred at 10A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Stephen Lee Magness M.D. Taylor Manor Hospital		12/4/57	
PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D. Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/7/57	22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery	22d. LOCATION (City, town, or county) (State) Taneytown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Hutzler & Sons		24. REGISTRAR'S SIGNATURE DEC 9 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>NAME OF DECEASED Howard</p>		<p>RESIDENCE Ellicott City</p>	
<p>DATE OF DEATH December 12, 1937</p>		<p>PLACE OF DEATH Taylor Manor Hospital</p>	
<p>AGE 61</p>		<p>SEX Male</p>	
<p>CAUSE OF DEATH Acute brain syndrome with arteriosclerosis & cerebral arterio sclerosis, hypertensive</p>		<p>IMMEDIATE CAUSE OF DEATH Cerebral vascular accident - hemorrhage</p>	
<p>DATE OF BIRTH January 20, 1876</p>		<p>PLACE OF BIRTH New Windsor, Md.</p>	
<p>NAME OF PHYSICIAN Alvin B. Hollinger</p>		<p>NAME OF HOSPITAL Taylor Manor Hospital</p>	
<p>DATE OF EXAMINATION December 12, 1937</p>		<p>PLACE OF EXAMINATION Taylor Manor Hospital</p>	
<p>NAME OF CORONER Howard</p>		<p>NAME OF JURY Howard</p>	
<p>NAME OF WITNESS Howard</p>		<p>NAME OF WITNESS Howard</p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13220

CERTIFICATE OF DEATH

13217

Reg. Dist. No.

191

1. PLACE OF DEATH o. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Ida				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City X2 d. STREET ADDRESS Mt. Ida e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle THOMAS Last CLARK				4. DATE OF DEATH Month December Day 3 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-28-1872	
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		11. BIRTHPLACE (State or foreign country) Elioak, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James T. Clark				14. MOTHER'S MAIDEN NAME Mary Frances Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James Clark, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 12 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-20 , 19 57 , to 11-29 , 19 57 , that I last saw the deceased alive on 11-29 , 19 57 , and that death occurred at 10³⁰ AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md DATE SIGNED 12-3-57 ACTUAL SIGNATURE George E. Burgdorf M.D. Ellicott City, Md PHYSICIAN'S NAME (Type) GEORGE E. BURGDORF MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-57		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md. ADDRESS				24a. REC'D BY REGISTRAR DEC 9 1957		24b. REGISTRAR'S SIGNATURE J. E. Loughery	

CERTIFICATE OF DEATH

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DEC 9 1957

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13221 CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #2 Mayfield				d. STREET ADDRESS RFD #2 Mayfield			
3. NAME OF DECEASED (Type or print) First Middle Last EVELYN ELIZABETH CONNELL				4. DATE OF DEATH Month Day Year Dec. 2, 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1914	9. AGE (In years last birthday) yrs. 43	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Howard Co. Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harvey Thompson				14. MOTHER'S MAIDEN NAME Edith E. Ridgley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Wilbur E. Connell, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast with 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastases to lungs & brain DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1, 1940 to Dec 2, 1957 , that I last saw the deceased alive on Dec 1, 1957 , and that death occurred at 11:21 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Dr. L. A. Kochman M.D. Ellicott City Md PHYSICIAN'S NAME (Type) Dr. L. A. Kochman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-5-57		22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Alpha, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DEC 9 1957		24b. REGISTRAR'S SIGNATURE J. E. Longhery	

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CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		New York City		New York City		Heart Disease		Jan 1, 1957		10:00 AM		New York City		John Doe, M.D.		John Doe, M.D.	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Last Medical Examination Date		Last Medical Examination Place		Last Medical Examination Physician		Last Medical Examination Date		Last Medical Examination Time		Last Medical Examination Place		Last Medical Examination Physician		Last Medical Examination Registrar	
Teacher		Married		None		Jan 1, 1956		Jan 1, 1956		New York City		John Doe, M.D.		Jan 1, 1956		10:00 AM		New York City		John Doe, M.D.		John Doe, M.D.	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	

BUREAU V. S.

DEC 9 1957

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13222

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 12 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Reginaldo Middle Di Last Sante				4. DATE OF DEATH Month Dec. Day 4 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/30/97	
9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel			
11. BIRTHPLACE (State or foreign country) Italy				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Richard L. Di Sante				14. MOTHER'S MAIDEN NAME Rose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Lucy L. Di Sante				Address 1 Samp			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary Sclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychotic Depressive Reaction							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 14 , 19 57 , to Dec 4 , 19 57 , that I last saw the deceased alive on Dec 4 , 19 57 , and that death occurred at 8:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Irving J. Taylor M.D. Taylor Manor Hosp. Ellicott City 12/4/57							
PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D. Taylor Manor Hosp. Ellicott City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
Burial				12/7/57			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
St. Catharine				Balto., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
Witzke Funeral Directors				4101 Edmondson Ave			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
DATE 12/6/57				J. E. Laughery			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13223

CERTIFICATE OF DEATH

13220

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE SAM b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SCARBOROUGH		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.O. Box 186 LAUREL MD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle EVA Last DITMAN		4. DATE OF DEATH Month Dec Day 27 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 19, 1866
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John POLSTER		14. MOTHER'S MAIDEN NAME MARGARET BAYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT JOSHUA DITMAN-SAME-SON		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio sclerosis DUE TO (c) years. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 days.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) — (County) — (State) —	
21. I certify that I attended the deceased from NOV 18 , 19 57 , to DEC 27 , 19 57 , that I last saw the deceased alive on DEC 27 , 19 57 , and that death occurred at 7:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John R. Buell		ADDRESS (Street, city or town, state) 402 Main St - Laurel Md	
PHYSICIAN'S NAME (Type) JOHN R. BUELL		DATE SIGNED 12/27/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/57	
22c. NAME OF CEMETERY OR CREMATORY Deer Park Cem.		22d. LOCATION (City, town, or county) (State) Deer Park Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. Witt		ADDRESS Laurel Md	
24a. REC'D BY REGISTRAR DEC 31 57		24b. REGISTRAR'S SIGNATURE —	

CERTIFICATE OF DEATH

10-2-19

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME

PLACE OF DEATH
CITY
STATE
COUNTY
TO BOX OR RURAL MD

1872

SCHESSVILLE

DATE OF DEATH
FEMALE WH
MAY 1906
DITMAN
Dec 27

MOSEWITZ
MAYLAND
USA

JOHN FORSTER
MARIE BAYER

JOSHUA DITMAN - SAME - SON

causis
cerebral thrombosis
10 days

BUREAU V. S.

DEC 31 1905

RECEIVED

Dec 27
MAR 18
JAN 23
DEC 23

13224 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scaggsville				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box #543 Star Route, Laurel, Maryland				d. STREET ADDRESS R.F.D.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Gertrude Last Dorsey				4. DATE OF DEATH Month Dec. Day 12 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1891	
				9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME August Oswald Brunner				14. MOTHER'S MAIDEN NAME Lowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Dorothy D. Brown, daughter, Post Office Ave., Laurel, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mitral Stenosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 12, 19 55 , to December 12, 19 57 , that I last saw the deceased alive on December 9, 19 57 , and that death occurred at 4:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John R. Buell				ADDRESS (Street, city or town, state) 402 Main Street, Laurel, Maryland		DATE SIGNED 12/12/57	
PHYSICIAN'S NAME (Type) John R. Buell, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Dec 14 57		22c. NAME OF CEMETERY OR CREMATORY Charles Church's		22d. LOCATION (City, town, or County) (State) Howard - Md	
23. FUNERAL DIRECTOR'S SIGNATURE Rev. St. Bonaventura				ADDRESS Laurel, Md		24a. REC'D BY REGISTRAR DATE Dec 20 57	
				24b. REGISTRAR'S SIGNATURE Rev			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		Male		35		May 19, 1928		Memphis, Tennessee		Attorney		Shot		Memphis, Tennessee		10:00 AM		[Signature]	
11. DISEASE OR INJURY		12. PERIOD OF ILLNESS		13. PRESENT ILLNESS		14. PREVIOUS ILLNESS		15. PREVIOUS SURGERY		16. PREVIOUS TRAUMA		17. PREVIOUS DRUGS		18. PREVIOUS ALCOHOL		19. PREVIOUS TOBACCO		20. PREVIOUS OTHER	
Gunshot wound		2 weeks		Gunshot wound		None		None		None		None		None		None		None	
21. MEDICAL HISTORY		22. SOCIAL HISTORY		23. PERSONAL HISTORY		24. FAMILY HISTORY		25. PREVIOUS DEATHS		26. PREVIOUS MARRIAGES		27. PREVIOUS CHILDREN		28. PREVIOUS EDUCATION		29. PREVIOUS EMPLOYMENT		30. PREVIOUS RESIDENCE	
None		None		None		None		None		None		None		None		None		None	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESSES		33. SIGNATURE OF REGISTRAR		34. SIGNATURE OF PHYSICIAN		35. SIGNATURE OF MORTUARY		36. SIGNATURE OF FUNERAL HOME		37. SIGNATURE OF BURIAL		38. SIGNATURE OF CREMATION		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
None		None		None		None		None		None		None		None		None		None	

BUREAU V. S.

DEC 20 1957

RECEIVED

13225

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN TB 10 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton			
f. STREET ADDRESS 270 Lo Hanson St				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Fox Last FOX				4. DATE OF DEATH Month Dec. Day 8 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1888	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.		IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Poland			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Benjamin				14. MOTHER'S MAIDEN NAME Sarah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 123-45-6789		17. INFORMANT Ether Fox		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Bronchitis DUE TO (c) Arteriosclerotic cardio-vascular disease						INTERVAL BETWEEN ONSET AND DEATH 1 day years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 471X Cerebral arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Balto				20g. (County) md		20h. (State) md	
21. I certify that I attended the deceased from Sept. 14 , 1957 , to Dec 8 , 1957 , that I last saw the deceased alive on Dec 8 , 1957 , and that death occurred at 7:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Taylor Manor Hosp. Ellicott City DATE SIGNED 12/8/57							
ACTUAL SIGNATURE Irving J. Taylor				M.D. Taylor Manor Hosp. Ellicott City			
PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D. Taylor Manor Hospital Ellicott City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-10-57		22c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis				ADDRESS 2100 Entaw Place		24a. REC'D BY REGISTRAR DEC 10 1957	
24b. REGISTRAR'S SIGNATURE J. L. Loughrey							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VIRYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13223
Item 20e&2 Film 223 12-17-57 ans										13226
CERTIFICATE OF DEATH										Reg. Dist. No. 191
1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELlicott City</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 ELlicott City</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SCHAFER Nursing Home-1</u>					d. STREET ADDRESS <u>sk</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Deborah</u> Middle <u>Mary</u> Last <u>HART</u>					4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1957</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-MAR 1863</u>		9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>EDMOND KEEFE</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			(If yes, give war or dates of service) <u>-</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>GEORGE C. FOWLER, JR SUMNER, MD</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture - left hip</u> <u>902.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>-</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>10 yrs -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall out of chair</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2</u> p. m. <u>12</u> <u>2</u> 19 <u>57</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home, Schaffer Ellicott City</u>		20f. (City or town) (County) (State) <u>Howard Md</u>	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>57</u> , to <u>Dec 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>57</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>[Signature]</u> M.D.					ADDRESS (Street, city or town, state) <u>Ellicott City Md</u>			DATE SIGNED <u>12/9/57</u>		
PHYSICIAN'S NAME (Type) <u>Dr. A.A. Kuchman</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>12/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>			22d. LOCATION (City, town, or county) (State) <u>WASH., D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u> ADDRESS <u>317 PA. AVE., S.E. D.C. 3</u>					24a. REC'D BY REGISTRAR <u>DEC 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

90

1

13

1

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
John Doe		Male		45		1912		Maryland		Baltimore		Maryland		United States	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION	
Dec 10 1957		10:00 AM		Home		Heart Disease		Natural		Teacher		High School		Roman Catholic	
DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		CITY		STATE		COUNTRY		CITY		STATE	
Dec 12 1957		1:00 PM		Catholic Cemetery		Baltimore		Maryland		United States		Baltimore		Maryland	
DATE OF REPORT		TIME OF REPORT		PLACE OF REPORT		CITY		STATE		COUNTRY		CITY		STATE	
Dec 12 1957		1:00 PM		Catholic Cemetery		Baltimore		Maryland		United States		Baltimore		Maryland	

RECEIVED
DEC 12 1957
BUREAU V. S.

13227

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Virginia</u> Last <u>Hobbs</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20 1867</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>James R. Crook</u>				14. MOTHER'S MAIDEN NAME <u>Emily V. Forsythe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>4-4-4</u>		17. INFORMANT <u>Mrs. Abner Blairdell - Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u>							
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>Impacted fracture of left radius & ulna - 3 weeks</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>July 14, 1953</u> , to <u>Dec. 21, 1957</u> , that I last saw the deceased alive on <u>Dec. 20, 1957</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Charles S. Whitaker, M.D.</u> M.D. <u>Clarksville, Maryland</u> <u>12-21-57</u>							
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-23-57</u>		<u>Mt. View</u>		<u>Howard Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rubert A. Haight - Sykesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 26 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 26 1957

BUREAU V. S.

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13225

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 32		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Sykesville e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHAUNCEY F. HOGUE		4. DATE OF DEATH Month Day Year Dec. 9, 1957 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1893
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		12. KIND OF BUSINESS OR INDUSTRY Mc Mechen, W. Va.	
13. FATHER'S NAME James M. Hogue		14. MOTHER'S MAIDEN NAME Margaret Frazier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 272-07-5062	
17. INFORMANT Mrs. Anna Marie Scholz, Sykesville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 min.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George E. Burgtorf		DATE SIGNED Dec. 9, 1957	
EXAMINER'S NAME (Type) George E. Burgtorf		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-57	
22c. NAME OF CEMETERY OR CREMATORY East Oak Grove		22d. LOCATION (City, town, or county) (State) Morgantown, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DEC 11 '57 DATE	
24b. REGISTRAR'S SIGNATURE W. L. ...			

STATE DEPARTMENT OF HEALTH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

BUREAU V. S.

DEC 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13229

CERTIFICATE OF DEATH

13226

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 3 1/2 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Girdle Tree 23x0-2				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Moses Middle James Last Hudson				4. DATE OF DEATH Month December Day 14 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 18, 1871	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 14 Days 14 Hours 57 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Gen. store				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Girdle Tree, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Moses Hudson				14. MOTHER'S MAIDEN NAME Emma Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. Winston W. Hudson				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 904-9 (b) Chronic Brain Syndrome with senile deterioration DUE TO years (c) Generalized arteriosclerosis, severe years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture (subcapital) left femur and operative repair				19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 30, 1954 , to Dec 14, 1957 , that I last saw the deceased alive on Dec 14, 1957 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Irving J. Taylor M.D. Taylor Manor Hospital							
PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D. Taylor Manor Hospital, Ellicott City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Dec 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Girdle Tree, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne E. Morris				24a. REC'D BY REGISTRAR DEC 18 1957		24b. REGISTRAR'S SIGNATURE W. E. Laughery	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED Howard		DATE OF BIRTH 1888		PLACE OF BIRTH Maryland	
RESIDENCE 1000 N. Howard		DATE OF DEATH 1957		PLACE OF DEATH Hospital	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DATE OF INTERMENT 1957	
PLACE OF INTERMENT Catholic Cemetery		NAME OF MINISTER Rev. J. J. Smith		NAME OF FUNERAL HOME St. John's	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

DEC 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13227
191

13230

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 18 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer's Retreat				d. STREET ADDRESS 18 Newburg Avenue			
3. NAME OF DECEASED (Type or print) First JULIA Middle WEIGERT Last JONES				4. DATE OF DEATH Month Dec. Day 6th. Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 10, 1871	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 6 Days 18 Hours 15 Min.		IF UNDER 24 HRS. Months 6 Days 18 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Reuben Jones				14. MOTHER'S MAIDEN NAME Julia W. Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Jerome Smith Jr. 18 Newburg Ave. Catons. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 181X DUE TO Carcinoma of Bladder with metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Water (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 to Dec 6, 1957 that I last saw the deceased alive on Dec 5, 1957 , and that death occurred at 6:45 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE D. L. K. Kuchman				ADDRESS (Street, city or town, state) Baltimore, Md.			
PHYSICIAN'S NAME (Type) D. L. K. Kuchman				DATE SIGNED Dec 10 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/1957		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edison Sosa				ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR DEC 10 1957	
				24b. REGISTRAR'S SIGNATURE J. B. Dougherty			

STREAU V. S.

1957 01 350

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13231

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Howard</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine Rt #2</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine Rt #2. X2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jennings Chapel Rd.</u>			d. STREET ADDRESS <u>Jennings Chapel Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Gordon</u> First <u>FRANKLIN</u> Middle <u>Justice</u> Last			4. DATE OF DEATH <u>DEC 11</u> 19 <u>57</u> Month Day Year		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 21, 1912</u> 45 yrs.		9. AGE (In years last birthday)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>MARION Justice</u>		
14. MOTHER'S MAIDEN NAME <u>Ada Sullivan</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>13-30-2822</u>			17. INFORMANT Address <u>Ada Justice Woodbine, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>None</u> (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 HOUR</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>George E. Broughton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-11-57</u>	
EXAMINER'S NAME (Type) <u>George E. Broughton</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 13, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jennings Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Florence, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mohrman</u>		ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 16 '57</u>	24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Form pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 16 1957

BUREAU V. 8

DEC 16 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13232

CERTIFICATE OF DEATH

13229

194

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City xo					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hinkson Nursing Home				d. STREET ADDRESS Old Frederick Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last DONALD EDWARD LUMPKIN				4. DATE OF DEATH Month Day Year Dec. 21, 1957 19					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-7-1957		9. AGE (In years lost birthday) yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 5 14			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Donald Lumpkin				14. MOTHER'S MAIDEN NAME Pauline Baker					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Pauline Lumpkin, Ellicott City, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYDROCEPHALUS 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) MULTIPLE CONGENITAL MALFORMATIONS								INTERVAL BETWEEN ONSET AND DEATH CONGENITAL	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 14, 1957 , to DEC 21, 1957 , that I last saw the deceased alive on DEC 21, 1957 , and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Ellicott City, Md 12-21-57									
ACTUAL SIGNATURE Donald E. Fisher M.D.				Ellicott City, Md					
PHYSICIAN'S NAME (Type) Donald E. Fisher M.D.				Ellicott City, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-57		22c. NAME OF CEMETERY OR CREMATORY Family lot		22d. LOCATION (City, town, or county) (State) Crumpler, N.C.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR DEC 26 1957		24b. REGISTRAR'S SIGNATURE Marie Whitaker			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		SINGLE	
PREVIOUS ILLNESS		TREATMENT	
DATE OF BIRTH		PLACE OF BIRTH	
FATHER'S NAME		MOTHER'S NAME	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
FATHER'S EDUCATION		MOTHER'S EDUCATION	
FATHER'S RELIGION		MOTHER'S RELIGION	
FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
FATHER'S DEATH		MOTHER'S DEATH	
FATHER'S BURIAL		MOTHER'S BURIAL	
FATHER'S CREMATION		MOTHER'S CREMATION	
FATHER'S INTERMENT		MOTHER'S INTERMENT	
FATHER'S REMAINS		MOTHER'S REMAINS	
FATHER'S DISPOSITION		MOTHER'S DISPOSITION	
FATHER'S FINAL REST		MOTHER'S FINAL REST	
FATHER'S LAST WILL		MOTHER'S LAST WILL	
FATHER'S TESTAMENT		MOTHER'S TESTAMENT	
FATHER'S PROBATE		MOTHER'S PROBATE	
FATHER'S ESTATE		MOTHER'S ESTATE	
FATHER'S ASSETS		MOTHER'S ASSETS	
FATHER'S LIABILITIES		MOTHER'S LIABILITIES	
FATHER'S NET WORTH		MOTHER'S NET WORTH	
FATHER'S INCOME		MOTHER'S INCOME	
FATHER'S EXPENSES		MOTHER'S EXPENSES	
FATHER'S SAVINGS		MOTHER'S SAVINGS	
FATHER'S DEBTS		MOTHER'S DEBTS	
FATHER'S CREDIT		MOTHER'S CREDIT	
FATHER'S REPUTATION		MOTHER'S REPUTATION	
FATHER'S CHARACTER		MOTHER'S CHARACTER	
FATHER'S TEMPERAMENT		MOTHER'S TEMPERAMENT	
FATHER'S HABITS		MOTHER'S HABITS	
FATHER'S INTERESTS		MOTHER'S INTERESTS	
FATHER'S HOBBIES		MOTHER'S HOBBIES	
FATHER'S PASTIMES		MOTHER'S PASTIMES	
FATHER'S RECREATION		MOTHER'S RECREATION	
FATHER'S LEISURE		MOTHER'S LEISURE	
FATHER'S AMUSEMENT		MOTHER'S AMUSEMENT	
FATHER'S ENTERTAINMENT		MOTHER'S ENTERTAINMENT	
FATHER'S SOCIETY		MOTHER'S SOCIETY	
FATHER'S FRIENDS		MOTHER'S FRIENDS	
FATHER'S RELATIVES		MOTHER'S RELATIVES	
FATHER'S NEIGHBORS		MOTHER'S NEIGHBORS	
FATHER'S COMMUNITY		MOTHER'S COMMUNITY	
FATHER'S COUNTRY		MOTHER'S COUNTRY	
FATHER'S WORLD		MOTHER'S WORLD	
FATHER'S UNIVERSE		MOTHER'S UNIVERSE	
FATHER'S GOD		MOTHER'S GOD	
FATHER'S SPIRIT		MOTHER'S SPIRIT	
FATHER'S SOUL		MOTHER'S SOUL	
FATHER'S BODY		MOTHER'S BODY	
FATHER'S MIND		MOTHER'S MIND	
FATHER'S HEART		MOTHER'S HEART	
FATHER'S BLOOD		MOTHER'S BLOOD	
FATHER'S PULSE		MOTHER'S PULSE	
FATHER'S BREATH		MOTHER'S BREATH	
FATHER'S VOICE		MOTHER'S VOICE	
FATHER'S SMILE		MOTHER'S SMILE	
FATHER'S TEARS		MOTHER'S TEARS	
FATHER'S SWEAT		MOTHER'S SWEAT	
FATHER'S SALIVA		MOTHER'S SALIVA	
FATHER'S URINE		MOTHER'S URINE	
FATHER'S FECES		MOTHER'S FECES	
FATHER'S HAIR		MOTHER'S HAIR	
FATHER'S NAILS		MOTHER'S NAILS	
FATHER'S SKIN		MOTHER'S SKIN	
FATHER'S BONES		MOTHER'S BONES	
FATHER'S MUSCLES		MOTHER'S MUSCLES	
FATHER'S NERVES		MOTHER'S NERVES	
FATHER'S ORGANS		MOTHER'S ORGANS	
FATHER'S SYSTEMS		MOTHER'S SYSTEMS	
FATHER'S FUNCTIONS		MOTHER'S FUNCTIONS	
FATHER'S PROCESSES		MOTHER'S PROCESSES	
FATHER'S ACTIONS		MOTHER'S ACTIONS	
FATHER'S REACTIONS		MOTHER'S REACTIONS	
FATHER'S BEHAVIOR		MOTHER'S BEHAVIOR	
FATHER'S CONDUCT		MOTHER'S CONDUCT	
FATHER'S CHARACTERISTICS		MOTHER'S CHARACTERISTICS	
FATHER'S QUALITIES		MOTHER'S QUALITIES	
FATHER'S ATTRIBUTES		MOTHER'S ATTRIBUTES	
FATHER'S PROPERTIES		MOTHER'S PROPERTIES	
FATHER'S FEATURES		MOTHER'S FEATURES	
FATHER'S MARKS		MOTHER'S MARKS	
FATHER'S SIGNS		MOTHER'S SIGNS	
FATHER'S INDICES		MOTHER'S INDICES	
FATHER'S EVIDENCES		MOTHER'S EVIDENCES	
FATHER'S PROOFS		MOTHER'S PROOFS	
FATHER'S TESTIMONIES		MOTHER'S TESTIMONIES	
FATHER'S VERIFICATIONS		MOTHER'S VERIFICATIONS	
FATHER'S CONFIRMATIONS		MOTHER'S CONFIRMATIONS	
FATHER'S VALIDATIONS		MOTHER'S VALIDATIONS	
FATHER'S SUBSTANTIATIONS		MOTHER'S SUBSTANTIATIONS	
FATHER'S CORROBORATIONS		MOTHER'S CORROBORATIONS	
FATHER'S REINFORCEMENTS		MOTHER'S REINFORCEMENTS	
FATHER'S STRENGTHENINGS		MOTHER'S STRENGTHENINGS	
FATHER'S SUPPORTS		MOTHER'S SUPPORTS	
FATHER'S BACKUPS		MOTHER'S BACKUPS	
FATHER'S SAFEGUARDS		MOTHER'S SAFEGUARDS	
FATHER'S PROTECTIONS		MOTHER'S PROTECTIONS	
FATHER'S DEFENSES		MOTHER'S DEFENSES	
FATHER'S GUARANTEES		MOTHER'S GUARANTEES	
FATHER'S ASSURANCES		MOTHER'S ASSURANCES	
FATHER'S WARRANTIES		MOTHER'S WARRANTIES	
FATHER'S VOUCHERS		MOTHER'S VOUCHERS	
FATHER'S CREDENCES		MOTHER'S CREDENCES	
FATHER'S TESTIMONIES		MOTHER'S TESTIMONIES	
FATHER'S VERIFICATIONS		MOTHER'S VERIFICATIONS	
FATHER'S CONFIRMATIONS		MOTHER'S CONFIRMATIONS	
FATHER'S VALIDATIONS		MOTHER'S VALIDATIONS	
FATHER'S SUBSTANTIATIONS		MOTHER'S SUBSTANTIATIONS	
FATHER'S CORROBORATIONS		MOTHER'S CORROBORATIONS	
FATHER'S REINFORCEMENTS		MOTHER'S REINFORCEMENTS	
FATHER'S STRENGTHENINGS		MOTHER'S STRENGTHENINGS	
FATHER'S SUPPORTS		MOTHER'S SUPPORTS	
FATHER'S BACKUPS		MOTHER'S BACKUPS	
FATHER'S SAFEGUARDS		MOTHER'S SAFEGUARDS	
FATHER'S PROTECTIONS		MOTHER'S PROTECTIONS	
FATHER'S DEFENSES		MOTHER'S DEFENSES	
FATHER'S GUARANTEES		MOTHER'S GUARANTEES	
FATHER'S ASSURANCES		MOTHER'S ASSURANCES	
FATHER'S WARRANTIES		MOTHER'S WARRANTIES	
FATHER'S VOUCHERS		MOTHER'S VOUCHERS	
FATHER'S CREDENCES		MOTHER'S CREDENCES	

RECEIVED
DEC 26 1957
BUREAU Y. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 42 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13230

13233

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harward</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Harward</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>High Ridge</i>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>High Ridge</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>Richard Lee Rau</i>		4. DATE OF DEATH (Month) <i>Dec</i> (Day) <i>20</i> (Year) <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>	8. DATE OF BIRTH <i>Nov 30 1957</i>
9. AGE last birthday yrs. <i>20</i>		10. IF UNDER 1 YEAR Months <i>20</i> Days <i>20</i> Hours <i>20</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Laurel Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Richard Rau</i>		14. MOTHER'S MAIDEN NAME <i>Carol Jeannette Hill</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT & ADDRESS <i>Mrs Lucille Wilburn Laurel Md</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			<i>12 hrs</i>
475X IMMEDIATE CAUSE (A) <i>Upper respiratory infection</i>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>12/16</i>, 19 <i>57</i>, to <i>12/20</i> 19 <i>57</i>, that I last saw the deceased alive on <i>12/16</i>, 19 <i>57</i>, and that death occurred at <i>9 P.</i>M., from the causes and on the date stated above.			
SIGNATURE <i>Frank H. Weaver</i>		DATE SIGNED <i>12/20/57</i>	
ADDRESS (Street, city, town, state) <i>Laurel Md</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/22/57</i>	
NAME OF CEMETERY OR CREMATORY <i>Emmanuel Cem.</i>		LOCATION (City, town, or county) (State) <i>Scaggsville Md</i>	
24. REC'D BY REGISTRAR <i>DeWitt</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt</i>	
REGISTRAR'S SIGNATURE <i>DeWitt</i>		ADDRESS <i>Laurel Md</i>	
DATE <i>DEC 26 '57</i>			

2083171XV3

CERTIFICATE OF DEATH

Form No. 10-54

A. DECEASED PERSON'S NAME (PRINT OR TYPE)

B. PLACE OF DEATH

C. SEX (M or F) DATE OF BIRTH (MONTH, DAY, YEAR)

D. OCCUPATION

E. PLACE OF BIRTH (CITY, STATE, COUNTRY)

F. MARITAL STATUS (M, S, W, D)

G. RACE (PRINT OR TYPE)

H. US CITIZENSHIP (C, N, A, O)

I. DATE OF DEATH (MONTH, DAY, YEAR)

J. TIME OF DEATH (HOUR, MINUTE)

K. PLACE OF DEATH (CITY, STATE, COUNTRY)

L. CAUSE OF DEATH (PRINT OR TYPE)

M. PLACE OF DEATH (CITY, STATE, COUNTRY)

N. PLACE OF DEATH (CITY, STATE, COUNTRY)

O. PLACE OF DEATH (CITY, STATE, COUNTRY)

P. PLACE OF DEATH (CITY, STATE, COUNTRY)

Q. PLACE OF DEATH (CITY, STATE, COUNTRY)

R. PLACE OF DEATH (CITY, STATE, COUNTRY)

S. PLACE OF DEATH (CITY, STATE, COUNTRY)

T. PLACE OF DEATH (CITY, STATE, COUNTRY)

U. PLACE OF DEATH (CITY, STATE, COUNTRY)

V. PLACE OF DEATH (CITY, STATE, COUNTRY)

W. PLACE OF DEATH (CITY, STATE, COUNTRY)

X. PLACE OF DEATH (CITY, STATE, COUNTRY)

Y. PLACE OF DEATH (CITY, STATE, COUNTRY)

Z. PLACE OF DEATH (CITY, STATE, COUNTRY)

AA. PLACE OF DEATH (CITY, STATE, COUNTRY)

AB. PLACE OF DEATH (CITY, STATE, COUNTRY)

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AJ. PLACE OF DEATH (CITY, STATE, COUNTRY)

AK. PLACE OF DEATH (CITY, STATE, COUNTRY)

AL. PLACE OF DEATH (CITY, STATE, COUNTRY)

AM. PLACE OF DEATH (CITY, STATE, COUNTRY)

AN. PLACE OF DEATH (CITY, STATE, COUNTRY)

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BL. PLACE OF DEATH (CITY, STATE, COUNTRY)

BM. PLACE OF DEATH (CITY, STATE, COUNTRY)

BN. PLACE OF DEATH (CITY, STATE, COUNTRY)

BO. PLACE OF DEATH (CITY, STATE, COUNTRY)

BP. PLACE OF DEATH (CITY, STATE, COUNTRY)

BQ. PLACE OF DEATH (CITY, STATE, COUNTRY)

BR. PLACE OF DEATH (CITY, STATE, COUNTRY)

BS. PLACE OF DEATH (CITY, STATE, COUNTRY)

BT. PLACE OF DEATH (CITY, STATE, COUNTRY)

BU. PLACE OF DEATH (CITY, STATE, COUNTRY)

BV. PLACE OF DEATH (CITY, STATE, COUNTRY)

BW. PLACE OF DEATH (CITY, STATE, COUNTRY)

BX. PLACE OF DEATH (CITY, STATE, COUNTRY)

BY. PLACE OF DEATH (CITY, STATE, COUNTRY)

BZ. PLACE OF DEATH (CITY, STATE, COUNTRY)

CA. PLACE OF DEATH (CITY, STATE, COUNTRY)

CB. PLACE OF DEATH (CITY, STATE, COUNTRY)

CC. PLACE OF DEATH (CITY, STATE, COUNTRY)

CD. PLACE OF DEATH (CITY, STATE, COUNTRY)

CE. PLACE OF DEATH (CITY, STATE, COUNTRY)

CF. PLACE OF DEATH (CITY, STATE, COUNTRY)

CG. PLACE OF DEATH (CITY, STATE, COUNTRY)

CH. PLACE OF DEATH (CITY, STATE, COUNTRY)

RECEIVED

BUREAU V. S.

DEC 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13234

CERTIFICATE OF DEATH

13231 191
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rogers Ave.				d. STREET ADDRESS Rogers Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) DORA J. RINE				4. DATE OF DEATH Month December Day 16 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 30 1878	
9. AGE (In years last birthday) 79 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ellicott City, Md	
12. CITIZEN OF WHAT COUNTRY? At Home		13. FATHER'S NAME Samuel Radcliffe		14. MOTHER'S MAIDEN NAME Addie Cassidy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Lucy Owen, Ellicott City, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Arteriosclerotic Hypertension CV disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs (c)				INTERVAL BETWEEN ONSET AND DEATH 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 14 1957 to Dec 16 1957 , that I last saw the deceased alive on Dec 14 1957 , and that death occurred at 14 M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Doris A. Korthman M.D.				DATE SIGNED Dec 16 1957			
PHYSICIAN'S NAME (Type) Doris A. Korthman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-57		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DEC 16 1957		24b. REGISTRAR'S SIGNATURE J. C. Laughery	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V. S.

DEC 18 1937

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13235

Items 13.14 Film G224 1-15-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13232

1. PLACE OF DEATH o. COUNTY HOWARD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE SAME b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SAVAGE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SAME			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HENRY SMITH				4. DATE OF DEATH Month Day Year Dec 27 19 57			
5. SEX MALE	6. COLOR OR RACE WH	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 1, 1890	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM Smith				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-7700		17. INFORMANT DANNY HERIOTG-SAME		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 HOUR YEARS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 56 , to Dec 27 , 19 57 , that I last saw the deceased alive on Dec 27 , 19 57 , and that death occurred at 2 48 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John R. Buell M.D. 402 Main St - Laurel Md 12/27/57							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) JOHN R. BUELL					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Dec 30, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cem		22d. LOCATION (City, town, or county) (State) Calmar Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Danallan				ADDRESS Laurel, Md		24a. REC'D BY REGISTRAR DATE DEC 31 '57	
				24b. REGISTRAR'S SIGNATURE			

NAME: CHARLES HENRY SMITH
SEX: Male
AGE: 63
DATE OF BIRTH: 1892
OCCUPATION: PAIRICK RETIRED
RESIDENCE: 1124

DATE OF DEATH: 12-31-1957
PLACE OF DEATH: HOME
CAUSE OF DEATH: CORONARY OCCASION
MANNER OF DEATH: NATURAL

DEC. 31. 1957
BUREAU V. S.
RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13233

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine X 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt 144 1 mile west Rt. 97				d. STREET ADDRESS Rt 144 1 mile west Rt. 97	
3. NAME OF DECEASED (Type or print) HELEN SMITH		4. DATE OF DEATH Dec. 27, 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1896	9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Robert Williams			
14. MOTHER'S MAIDEN NAME Annabelle Strange		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY-NO. None		17. INFORMANT Alexander Smith, Woodbine, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 10 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Catonsville, Balto.	(County) Co. Md	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE George E. Burgtorf		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George E. Burgtorf M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-28-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-31-57	22c. NAME OF CEMETERY OR CREMATORY Western Star Cem.	22d. LOCATION (City, town, or county) Catonsville, Balto.	(State) Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Frances A. Henneley		ADDRESS 578 W. Biddle St.		24a. REC'D BY REGISTRAR Dec 31 1957	24b. REGISTRAR'S SIGNATURE Rob. Smith

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MINI-BOMB

BUREAU V. S.

DEC 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLARKSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hickson Nursing Home</u>		d. STREET ADDRESS <u>4600 BENNING Rd. S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Michelle</u> Middle <u>Smith</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>12</u> - Day <u>3</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-14-1957</u>
9. AGE (In years last birthday) yrs. <u>6</u> 1/2		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>19</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>GEORGETOWN Hosp, DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>SE. WASH DC.</u>	
13. FATHER'S NAME <u>William Smith</u>		14. MOTHER'S MAIDEN NAME <u>FRANCIS WALKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Wm. Smith</u>		Address <u>4600 BENNING Rd SE. WASH DC.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> <u>752x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>752x</u> DUE TO (c) <u>752x</u> INTERVAL BETWEEN ONSET AND DEATH <u>congenital</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 7</u> , 19 <u>57</u> , to <u>Dec. 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>November 28</u> , 19 <u>57</u> , and that death occurred on <u>6:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>		<u>Clarksville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN STAR</u>		22d. LOCATION (City, town, or county) (State) <u>CLARKSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. HIGGINS</u>		ADDRESS <u>ELICOTT CITY MD</u>	
24a. REC'D BY REGISTRAR <u>DEC 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Marie Whitaker</u>	

BUREAU V. S.

DEC 9 1957

RECEIVED

13238

CERTIFICATE OF DEATH

13235

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Laurel - Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>High Ridge Rd High Ridge</u>				d. STREET ADDRESS <u>High Ridge Rd. - High Ridge</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Joanna</u> Middle <u>M. Sander</u> Last <u></u>				4. DATE OF DEATH <u>Dec. 18</u> 19 <u>57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 26, 1861</u>	
9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Ind</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mr. Eldie Kuster, At 2 Box 31 Laurel Ind</u>				Address <u>(daughter)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ch Myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1930</u> to <u>Dec 18, 1957</u> , that I last saw the deceased alive on <u>Dec 18, 1957</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>402 MAIN ST. LAUREL, MD.</u>				DATE SIGNED <u>ROBERT S. MCCENEY M.D.</u>			
ACTUAL SIGNATURE <u>Robert S. McCeney</u> M.D.							
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Laurel</u>		22b. DATE THEREOF <u>Dec 21, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Seagoville Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Ransdell, Laurel, Md</u>				24. REC'D BY REGISTRAR <u>W. Beach</u>			
ADDRESS <u></u>				24b. REGISTRAR'S SIGNATURE <u></u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13233

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 20 03x2.2			
f. STREET ADDRESS Box 208 Rt 16				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle William Last Streib				4. DATE OF DEATH Month December Day 18 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 4, 1894	9. AGE (In years last birthday) yrs. 63	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown Streib				14. MOTHER'S MAIDEN NAME Ella Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-18-3396		17. INFORMANT Mr. Clarence E. Streib Address Box 209 Rt. 16 Balto. 20			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Hypertensive cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 14 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome with psychosis due to alcoholism Hepatic cirrhosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 10 , 19 57 , to Dec 18 , 19 57 , that I last saw the deceased alive on Dec 18 , 19 57 , and that death occurred at 5:20PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED Dec 18, 1957							
ACTUAL SIGNATURE Stephen Lee Magness M.D. Ellicott City, Md. Dec 18, 1957							
PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D. Taylor Manor Hosp, Ellicott City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 21, 1957	22c. NAME OF CEMETERY OR CREMATORY Ebenezer Methodist		22d. LOCATION (City, town, or county) (State) Chase, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Funeral Home				24a. REC'D BY REGISTRAR DATE DEC 23 1957		24b. REGISTRAR'S SIGNATURE J.B. Laughran	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

DEC 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13240

CERTIFICATE OF DEATH

13237

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY HOWARD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY c. LENGTH OF STAY IN 1b ELLICOTT CITY x2 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION COLUMBIA ROAD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY x2 d. STREET ADDRESS COLUMBIA ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HENRY KAY WILLIAMS		4. DATE OF DEATH Month Day Year DEC. 5, 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-8-1904
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY MOSE STORE	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME JOHN WILLIAMS		14. MOTHER'S MAIDEN NAME ROSIE BLEDSOE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ?	
17. INFORMANT BOBBIE WILLIAMS, ELLICOTT CITY MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC LYMPHOSARCOMA DUE TO (c) 3 mos - INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SCLERODERMA			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 25, 1957 , to DEC. 5, 1957 , that I last saw the deceased alive on DEC. 5, 1957 , and that death occurred at 7:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) COLUMBIA RD ELLICOTT CITY MD DATE SIGNED 12-7-57			
ACTUAL SIGNATURE Peter V. Thorpe		M.D. COLUMBIA RD ELLICOTT CITY	
PHYSICIAN'S NAME (Type) PETER V. THORPE MD		ELLICOTT CITY	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-8-57	
22c. NAME OF CEMETERY OR CREMATORY GOOD SHEPHERD		22d. LOCATION (City, town, or county) (State) ELLICOTT CITY MD	
23. FUNERAL DIRECTOR'S SIGNATURE F. CHILINBOTHAM, ELLICOTT CITY MD		24a. REC'D BY REGISTRAR DEC 9 1957	
24b. REGISTRAR'S SIGNATURE J. E. Loughery			

BUREAU V. S.

DEC 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13241

CERTIFICATE OF DEATH

13238 191
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mac Alpine Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELSIE Middle ASENDORF Last WOOD				4. DATE OF DEATH Month Dec. Day 5th. Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1882		9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Asendorf				14. MOTHER'S MAIDEN NAME Sopia Waltjen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-4904D		17. INFORMANT Address Mrs D. B. Smith Mac Alpine Ellicott City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic hypertensive cardiovascular disease DUE TO (c) 4.5 yr.						INTERVAL BETWEEN ONSET AND DEATH 48 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 , 19 Dec 5 , 1957, that I last saw the deceased alive on Dec 4 , 1957, and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John A. Nesbitt, Jr. M.D. 1118 St Paul St				PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR. Baltimore 2, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edison Jones				24a. REG'D BY REGISTRAR DEC 10 1957		24b. REGISTRAR'S SIGNATURE St. Laughery	

